GOVERNMENT OF ANDHRA PRADESH
ABSTRACT

Commissionerate of Health and Family Welfare – Conversion of Dispensaries, Civil Hospitals, Subsidiary Health Centres and MMUs as Primary Health Centres (PHCs) / Community Health Centres (CHCs) and Establishment of Community Health and Nutrition Clusters (CHNCs) – Orders - Issued.

HEALTH, MEDICAL AND FAMILY WELFARE (F.I) DEPARTMENT

G.O.Ms.No. 92 **Dated: 23-04-2010.**

1. From the DH, Lr. No. Rc/ Spl./AD (Plg.)/2008, dt.21.07.2008.
2. From the DH, Lr. No. Rc/ Spl./AD (Plg.)/2008, dt.21.11.2008.
3. G.O.Ms.No.355 HM&FW (C1) Dept., dt. 12.9.2001
4. G.O.Ms No. 637 HM&FW (G1) Dept., dt. 3.11.2003
5. G.O.Ms No. 448 of HM&FW (F1) Dept., dt. 30.12.2008

* * *

ORDER:

The Director of the Department of Health, Government of Andhra Pradesh, in the reference first cited, has submitted comprehensive proposals for conversion of Government Dispensaries (GDs), Government Civil Hospitals (GCHs), Subsidiary Health Centres (SHCs) and Mobile Medical Units (MMU) existing in the rural areas as Primary Health Centres (PHCs) / Community Health Centres (CHCs), as the case may be, based on the infrastructure and the human resources available at these health facilities.

2. The Director has submitted that Primary Health Centre' (PHC) is the cornerstone of rural health services that provides comprehensive preventive, promotive and curative health care to twenty to fifty thousand rural population. Therefore, the rural areas of Andhra Pradesh should have about 1,892 PHCs across the state in order to deliver effective primary health services. However, currently only 1,571 PHCs are functioning throughout the state, which indicates a substantial shortfall in access to rural citizens, especially those living in remote and interior areas of the state.

3. Further, the Director of Health has informed that one hundred seventeen (117) GDs, thirty-four (34) GCHs, twenty-six (26) SHCs and twenty-five (25) MMUs are currently functioning in different parts of the state. These institutions, which might have had some historical significance, are anachronistic in the contemporary primary health architecture. By virtue of their limited mandate and constricted resource base, these institutions have not been able to contribute effectively to the goal of securing universal access to primary health services for all rural citizens of the state. Moreover, the existence of these institutions has prevented effective rationalisation of the primary health care institutions and their service area and stymied efforts to strengthen the PHC / CHC system by competing for resources.

(P.T.O.)

4. In this context, the Government has decided to strengthen the primary health system through a series of measures, which include amongst several others: rationalising the nomenclature, functions, responsibilities and service area of all health institutions in the state. Accordingly, the Government after careful examination of the proposal of the Director of Health - with inputs from the Strategic Planning and Innovation Unit (SPIU) of the Department and the Commissioner of Family Welfare - has decided that the entire rural area of the state should be organised into a series of Community Health and Nutrition Clusters (CHNCs), with each cluster providing comprehensive primary health care services to about one to two lakh rural population. Each CHNC will comprise of a Community Health Centre (CHC) and a cluster of five to ten PHCs along with their Sub-Centres, depending on the population, distance, remoteness, disease burden, etc.

5. The Community Health Centre (CHC) will be the nucleus of the CHN Cluster that would provide the dynamic interface between the primary and secondary health system. Each CHC, as the First Referral Unit (FRU), shall be fortified with Comprehensive Emergency Obstetric and Neonatal Care (CEMONC Centre) facility. Each CHC shall monitor, guide and support a cluster of five to ten PHCs. Each PHC in turn will support, guide, monitor and facilitate the functions of about five to fifteen Sub-Centres (SCs), based on population, distance, access, remoteness, disease burden etc.

6. To augment the primary health system, the Government hereby orders for conversion of the existing two hundred and three (203) Health institutions (viz. Govt. dispensaries, Civil Hospitals, Mobile Medical Units etc.) in the rural and remote areas of the state into PHCs / CHCs, as the case may be, based on the existing human resources, location, infrastructure, etc. The details of these Health institutions are shown in the Annexure-I appended to this order.

7. Further, the Government orders that the directions issued in the reference 3rd cited, wherein certain PHCs / CHCs were ordered to be transferred from the Directorate of Health to AP Vaidya Vidhana Parishad (APVVP) and vice versa, shall be considered while demarcating the Community Health and Nutrition Clusters and the service area of each CHC, PHC and the Sub-centre.

8. It is hereby ordered that all subsidiary PHCs, Mandal PHCs, Block PHCs, Upgraded PHCs, 24/7 PHCs, Modified PHCs, Stationery PHCs, and such other assorted health institutions shall be converted either as a PHC or as a CHC based on the infrastructure, human resources, need, location, etc. It is ordered that effective the date of issuance of this order, there shall be only CHCs, PHCs, and Sub-Centres in the primary health system (Directorate of Public Health and Family Welfare) and Area and District Hospitals in the secondary health care system (AP Vaidya Vidhana Parishad). Accordingly, the nomenclature as well as the functions of all health institutions in the rural areas of the state shall be rationalised forthwith.

(Contd..3)

9. Considering the addition of two hundred and three health institutions to the primary health system, the service area of all Sub-centres, PHCs and CHCs are ordered to be rationalised duly considering the ease of access to the citizens as the central principle for such rationalisation. It is ordered that the service of health institutions shall be rationalised to ensure that each Sub-centre serves about two to five thousand population and a PHC provides preventive, promotive and curative health services to about twenty to fifty thousand population and a CHNC provides primary health care to about one to two lakh rural population. While undertaking the rationalisation exercise, the guidelines of the Government issued in Memo No. 12231/F1/2008 dated 23 April 2010 shall be followed scrupulously.

10. The Commissioner of Health and Family Welfare, Director of Public Health and Family Welfare, the Commissioner of AP Vaidya Vidhana Parishad and the District Collectors shall take necessary action accordingly.

11. This order is issued with the concurrence of Finance (Exp. M&H.II/2010) U.O No.2260/33/A2 Dated 22.2.2010.

(BY ORDER AND IN THE NAME OF THE GOVERNOR OF ANDHRA PRADESH)

DR. P. VENKAT RAMESH
SECRETARY TO THE GOVERNMENT

To

The Commissioner of Health and Family Welfare.
The Director of Public Health and Family Welfare.
The Commissioner of AP Vaidya Vidhana Parishad.
All District Collectors and District Magistrates.
All District Medical and Health Officers.
All District Coordinators of Health Services of APVVP.
All Superintendents of Area and District Hospitals.

Copy to:

1. The Secretary to Government of India, Ministry of Health and Family Welfare, Nirman Bhavan, New Delhi.
2. The Secretary to Government of India, Department of Medical Research, Ministry of Health and Family Welfare, Nirman Bhavan, New Delhi.
3. The Director-General of Health Services, Ministry of Health and Family Welfare, Government of India, Nirman Bhavan, New Delhi.
4. The Mission Director, NRHM, Nirman Bhavan, New Delhi.
5. The Director, NIHFW, New Delhi.
6. The Principal Secretaries / Special Secretaries to the Chief Minister.
7. Director of Medical Education / Director of IPM / Commissioner of AYUSH / Director General of Drug Control Administration / Managing Director of APHMHIDC / Project Director of APSACS / Director of Indian Institute of Health & Family Welfare / Vice-Chancellor of NTR University of Health Sciences.

(P.T.O.)

8. The OSD to Hon'ble Minster (ME), AP Secretariat, Hyderabad.
9. The OSD to Hon'ble Minster (H&FW), AP Secretariat, Hyderabad.
10. The OSD to Hon'ble Minster (Aarogyasri, 108,104 & APHMHIDC), AP Secretariat, Hyderabad.
11. All Regional Directors of Health.
12. All Nodal Officers (Health Reform) of the Department of Health and Family Welfare.
13. All the DM&HOs / District Coordinator of Health Services (DCHS).
14. All Superintendents of Teaching / District / Area Hospitals.
15. Principals of Medical College of the state.
16. The Director of Treasury and Accounts, AP Hyderabad.
17. The PS to the Principal Secretary to Government, Medical and Health Department.
18. Finance (Expr .M &HII) and (SMPC) Depts.
19. All Officers / Sections in HM&FW Dept.
20. SPIU of HM &FW Department.
21. Representative, Family Health International Hyderabad.
22. Director, Indian Institute of Public Health, Hyderabad.

//FORWARDED:: BY ORDER//

SECTION OFFICER

GOVERNMENT OF ANDHRA PRADESH
HEALTH, MEDICAL AND FAMILY WELFARE (F1) DEPARTMENT

Memo No. 12231/F1/2008 **Dated: 23-04-2010**

Subject:- Revitalisation of Primary Health System in Andhra Pradesh – Rationalisation of Health Facilities, Constitution of Community Health and Nutrition Clusters (CHNCs) and Delineation of Service Area of Community Health Centres (CHCs), Primary Health Centres (PHCs) and Sub-Centres (SCs) – Guidelines - Issued.

Reference:- G.O.Ms No 92 of Medical, Health & Family Welfare Department, dated 23.04.2010

1. In the reference cited, the Government have ordered for conversion of two-hundred and three (203) Government Dispensaries (GDs), Government Civil Hospitals (GCHs), Subsidiary Health Centres (SHCs) and Mobile Medical Units (MMU) in the rural areas of the state as Primary Health Centres (PHCs) / Community Health Centres (CHCs). Further, the Government have directed that the primary health services in the rural areas of the state be strengthened through Community Health and Nutrition Clusters (CHNCs), each comprising of a referral centre (a Community Health Centre (CHC) or a Area Hospital) and a cluster of Primary Health Centres (PHCs) and the attached Sub-Centres. Further, government have ordered that the service area of all primary health institutions (CHCs, PHCs and SCs) and the functionaries be rationally organised to ensure equitable access to quality health care for all citizens of the state. In this direction, the government is issuing the following guidelines for rationalising the service area of the health institutions and the functionaries.

2. **The Objective.** The Government of Andhra Pradesh has been making sustained efforts to provide quality health care to its citizens, with special attention to those living in remote and interior locations and those belonging to the disadvantaged strata of the society. In this direction, the Government has been implementing the National Rural Health Mission (NRHM), along with several other schemes, programmes and activities with the aim of achieving the Millennium Development Goals (MDGs) by making the health delivery system effective and responsive to the needs of the people.

3. The Government 's endeavour is to strengthen the capacity of the health delivery system for effective prevention and efficient management of diseases; provision of universal and comprehensive reproductive and child health services; strengthening the referral system and improving the quality of hospital care in conformity with the Indian Public Health Standards (IPHS). The first amongst a series of interventions in this direction is to create the institutional architecture that would enable effective and efficient functioning of the health delivery system.

4. **The Framework.** To ensure effective monitoring, co-ordination, and support to the PHCs and the Sub-centres, and to strengthen the referral system, especially between the primary and secondary health system, the Government has decided to organise primary health care delivery to the rural areas through 'Community Health and Nutrition Clusters (CHNCs). Each Cluster would provide health services to one to two lakh rural citizens living in the villages serviced by 4 to 8 adjacent PHCs, with a Referral Hospital as the Mentoring Institution (MI). The CHC (either under DH or APVVP control) as the first referral unit (FRU), would provide Comprehensive Emergency Obstetric and Neonatal Care (CEMONC) for the cluster and would also be the head quarters of the Community Health Co-ordination Unit (CHCU) that would supervise, monitor and coordinate the functioning of PHCs and perform the mentoring role. In the absence of a CHC within the cluster, an Area Hospital will be the Mentoring Institution and will house the CHCU. The Mentoring Institution will therefore play a dual role; one of being the first referral unit and second of being the co-ordination unit.

5. The primary health system shall comprise of three-tier system of sub-centre, PHC and CHC. All other institutions like: subsidiary PHCs, upgraded PHCs, Mandal PHCs, 24/7 PHCs, stationery PHCs, Block PHCs, government dispensaries, mobile medical units, government civil hospitals, etc., should be converted as either a PHC or a CHC depending on population, access, infrastructure, staff, demand for services etc. It should be noted **that no new health institutions are being sanctioned during the current year**. The principal endeavour is to strengthen the existing system rather than expand the institutions at this juncture.

6. **The Coverage.** The current exercise is limited to the rural areas, tribal areas and grade-3 and 2 municipalities, but does not include Municipal Corporations and Grade-1 Municipalities. Similar exercise for the urban areas (Grade I Municipalities and Corporations) will be undertaken separately. This exercise envisions that all health institutions in the rural areas - like dispensaries, civil hospitals, mobile medical units, subsidiary health centres, upgraded PHCs, Mandal PHCs/24-hour PHCs, etc. – will be converted either as a PHC or a CHC. However,

in this process, **no health institution will be closed, shifted, or reduced in status from its current position**, unless there are compelling reasons for doing so, like for example, two health facilities being located either in the same or in the adjacent villages. If such an action is mandated for any strong reason, the same shall be justified with evidence and due approval be obtained from the District Health Committee.

7. **Revitalisation of Primary health Care System.** The process for revitalisation of primary health system include the following:

a) Rational organization of the service area of ASHA worker, sub-centre, and PHC and filling the gaps for universal coverage;
b) Constitution of Community Health and Nutrition Clusters (CHCN) and Measures for Streamlining the Referral System;
c) Review and defining the package of services provided by the Sub-centres and PHCs and clear delineation of service area and functional responsibilities of each and every staff member in the CHCN;
d) Rationalisation of Human Resources, Equipment and Infrastructure; and
e) Action Plan for Strengthening the Health Institutions and the Quality of Care.

Service Area Rationalisation

8. The primary health system comprises of hierarchically organised but inter-connected, mutually supportive system of three-tier institutions; sub-centre, PHC and the CHC. The spatial distribution of these institutions should ensure equitable access to all citizens to comprehensive primary health services. The service area of each institution, i.e., sub-centre, PHC and CHC, should be clearly defined so that every person living in that area is aware not only of the health institution responsible for package of services for his / her village but also the referral network. The objective is to provide access for every citizen to quality health care system.

9. **This exercise should start from the habitation level and proceed to the higher levels and not vice versa.** This would entail that the service area of the ASHA worker is delineated first, followed by the Sub-centre and the PHC. Once the service area of all PHCs are clearly defined, the constitution of community health and nutrition clusters (CHNC) would be the logical evolution. The service area delineation should adhere to the Indian Public Health Standards (IPHS).

10. ASHA Worker Service Area: The first step is to rationalise the service area of ASHA worker. Every ASHA worker should have a well defined service area duly taking the habitation of the village as the unit for service area. Every habitation

of the village must receive the services of ASHA worker. Special attention must be paid to ensure that all SC, ST and Minority habitations have access to the services of ASHA worker. If any habitation is not currently reached by the ASHA worker, proposal must be made for either another ASHA worker or action be taken to utilise the services of the existing Community Resource Person (CRP) of the local Village Organisation (VO) or the Anganwadi Worker as the link health worker. In the tribal areas, the Community Health Worker (CHW) shall be the ASHA worker, wherever they exist. The service area of an ASHA worker should be within a radius of one kilo meter.

11. Sub-Centre Service Area: Each sub-centre should provide services to about 3,000 to 5,000 population in the plain areas, and this norm should be substantially less in the tribal areas. In the plain areas, it is expected that each SC will serve 4 to 5 villages located at a distance of 1 to 5 km. The Sub-centre must be equidistant from the villages it serves and be located at the centre of its service area to the extent possible. This might necessitate moving one or more existing village from one sub-centre to another, even if it means that village is in another Mandal. **Proximity and access alone should be considered while delineating the service area. A revenue village should be the unit for organising the service area of the sub-centre, while a habitation should be the unit for organising the ASHA service area.**

12. The service area of the Sub-centre should be divided and clearly demarcated for each of the two ANMs, duly ensuring that the service area of each ANM is contiguous. This exercise should be done with greatest diligence in the tribal areas of the state. It shall be noted that no new sub-centres are being sanctioned at this moment. However, if there are compelling reasons for either creating or shifting any sub-centre, the same shall be submitted as part of the proposal for strengthening the CHN Cluster.

13. PHC Service Area: Each PHC should support about six to ten sub-centres located within a distance of 5 to 25 kms. The PHC service area rationalisation should include review and delineation of sub-centres attached to each PHC duly ensuring that the sub-centres are nearly equidistant from the PHC. In this configuration, a CHC will not directly support sub-centres and instead would be a mentoring, guiding and support facility for the PHCS. Therefore, sub-centres attached to any CHC should be transferred to the direct management of the adjacent PHC to the extent possible. The service area of the PHC can include villages in more than one Mandal, since the principle is ease of access to the citizens rather than administrative convenience should guide the rationalisation process. Each PHC should provide comprehensive preventive, promotive, curative and referral services to about 30,000 to 50,000 rural citizens.

14. If the existing PHC is located at the extreme corner of its service area, an earnest effort must be made to see that its service area becomes more manageable by redistributing the sub centres and become more equidistant from PHC. If two health institutions, especially a PHC and a CHC, are located in the same village, one of them would have to be relocated to another village. If two PHCs are located very close to each other, the PHC in a rented building may be shifted another suitable place for better coverage and function. **Henceforth, all PHCs and CHCs should provide services round the clock. Therefore there should not be any distinction such as Mandal PHCs, 24/7 PHCs etc.**

Constitution of Community Health and Nutrition Clusters (CHNC)

15. The rationalisation of service area of the ASHA worker, Sub-centre and the PHC should be followed by delineation of Community Health and Nutrition Cluster (CHNC), with the Community Health Centre (CHC) as the First Referral Unit (FRU) and the Mentoring Institution (MI). An Area Hospital could be the MI if there is no CHC in the cluster. Four to ten PHCs surrounding the CHC should be tagged on to the Referral Hospital. The service area of all the PHCs so tagged would constitute the CHN Cluster. Each CHNC is expected to provide services to about one to two lakh rural citizens.

16. The Cluster Institution or the Mentoring Institution, as mentioned above, will perform dual functions. On one hand, it will function as the first referral unit providing Basic or Comprehensive Emergency Obstetric and Neonatal services (BEMONC or CEMONC) based on the infrastructure and specialist doctors, while on the other, it will be the headquarters of Community Health Coordination Unit (CHCU), which will be responsible for supervision, monitoring, co-ordination and mentoring of all PHCs and Sub-centres within the CHN cluster.

17. Streamlined Referral System: The effectiveness of the health system can be strengthened through streamlined referral system. This will reduce congestion in the outpatient clinics, ensure faster and effective specialist treatment and avoidable costs for the patient. This is particularly important for reducing MMR and IMR, particularly neonatal morbidity and mortality. The CHC shall be the FRU for all the PHCs under its supervision. While the patient has a choice of a health facility, it shall be the duty of the PHC to guide and direct the patient to its FRU. All CHCs will be strengthened to provide comprehensive emergency obstetric and neonatal care during the current 5-year plan. Each CHC must have an Obstetrician, Paediatrician and an Anaesthetist and preferably a General Physician. The plan of action for revitalisation should include specific proposals in this regard. The free standing

health institutions of the Medical, Health and Family Welfare Department like the PP units, MCH Centres, FP Centres, CEMONC centres etc., should be integrated with the CHC and appropriate proposal must be made in the plan for revitalisation.

18. The FRU can be a CHC under the control of Director of Public Health or belonging to the APVVP or an area Hospital. An upgraded PHC or a Civil Hospital may be proposed for conversion as a CHC only if it has the required staff and the infrastructure. The Community Health Co-ordination Unit, however, will be under the direct control of the Directorate of Public Health.

19. Community Health Coordination Unit (CHCU): The Mentoring Institution will also be the headquarters of the CHCU. A DCS or the senior-most medical officer in the CHN Cluster will be designated as the Cluster Co-ordinator, who will be responsible for the overall supervision and monitoring of the functioning of all PHCs in the cluster. The CHCU will integrate the functionaries of all institutions responsible for primary health care, and will include the PHN, Ophthalmic Officer, Sub-Unit Officer (Malaria) and the functionaries responsible for Leprosy and HIV/AIDS in the cluster.

20. The Community Health Cluster Coordinator (CHCC) would be responsible for the overall coordination and supervision of all primary health functions in the CHN Cluster, but would not be responsible for the management of the FRU. Until an officer is designated as the CHCC, the Superintendent of the Cluster Hospital (CHC or Area Hospital, as the case may be) or the senior most medical officer in the cluster or the deputy civil surgeon in the cluster – whoever is the most senior – would function as the CH Cluster Coordinator. The Coordinator will undertake extensive tour in the cluster and monitor and guide effective implementation of the primary health care activities in the cluster and secure synergy and integration with nutrition and socio-economic development activities of the Rural Development and Women Welfare and Child Development Department activities.

21. The CHCC will be the most important functionary in the CHN cluster responsible for all activities of the medical and health department in the cluster. The PHC MOs will report to the Deputy DMHO / DMHO only through the CH Cluster Coordinators. The government in due course will empower the CHCC to perform all functions of the department in the cluster. One district level programme officer will be designated as the Nodal Officer for each revenue division, who along with the Deputy DMHO will co-ordinate and monitor the functions of all CHCCs.

Action Plan for Strengthening the Health Institutions and Quality of Care

22. After rationalisation of the service area of Sub-centres and PHCs and constitution of CHN Clusters, a comprehensive plan should be prepared to: a) define the area of operations and the functions of each and every functionary of the Medical, Health and Family Welfare Department in the CHN Cluster; and b) based on this review a proposal must be prepared for rational deployment of the staff to ensure equitable distribution of staff amongst all PHCs; c) those functionaries with area of operation beyond one PHC should be located at the CHCU under the direct control and supervision of Cluster Co-ordinator and they shall be responsible for services to all PHCs in the Cluster. It should be noted that no new staff will be sanctioned and every effort must be made to ensure optimum deployment and productivity of each and every staff member of the department. While finalising the action plan, especially in backward and remote areas, alternative options like involving non-governmental organisations and other creative and innovative proposition.

23. While undertaking this exercise, the following package of services to be provided at the PHC and Sub-Centre shall be taken in to consideration.

Package of Services at the PHC / Sub-Centre

24. One of the key inputs to effective health care delivery envisages well-defined roles and responsibilities for the Sub centre, PHC and CHC and all its functionaries. The PHC should reach out to the community and provide integrated – RCH, disease prevention and management, health promotion, etc. - and comprehensive preventive, promotive and curative – services. The PHC should effectively utilise the services of all its staff and all field staff, especially the Medical Officers, should visit each and every village in its service area at least once a month. Ideally each PHC should have two medical officers; and they should be mobile for atleast six days a week. Where there is only one MO, she/ he shall be mobile for atleast four days a week.

25. Some of the key functions of the PHC include the following:

a) Role of the Medical Officer at the PHC: Curative activity following the standard treatment protocols; referral of patients who need specialist care; laboratory monitoring; indenting medicines as per the disease burden; overall management of the staff and the resources, including review and

reporting of all primary health activities. Above all, the MO shall be responsible for prevention and management of infectious diseases, environmental sanitation, safe motherhood and child survival and monitoring of all pregnant and lactating women and children below 5 years.

b) MOs role in the field: MO must visit every sub-centre and every village in the service area of the PHC on a fixed day of the week/Fortnight. The PHCs with 4-5 sub-centres will receive the MO once every week and those with more sub-centres, once in a fortnight. All villages should receive MOs visit atleast once a month. PHC The list of services to be provided in the field are:-

i. Ante-Natal Care (ANC): first trimester registration of all pregnancies; screening for pre-existing diseases and their treatment; four ANC visits (3 by the MO); three TT injections; regular intake of Iron and Folic Acid (IFA) tablets throughout pregnancy for not less than 120 days; supplementary nutrition; identification of high risk pregnancies; birth planning for all in the third trimester; and ensuring institutional delivery / skilled birth attendance; post-natal care. Monitoring of prenatal, intranatal and postnatal complications and prompt referral to the Referral Hospital.

ii. Child health screening using IMNCI protocols where applicable: age groups of
    1. 0-1 year: Immunization, growth monitoring, exclusive breast feeding and weaning advice, treatment of pre-existing conditions, care of Grade 3 and 4 malnutrition children in health facility/FRU and screening for childhood illness and referral as appropriate.
    2. 1-5years: immunisation, growth monitoring, vitamin A supplementation, nutrition support.
    3. 5-15 years: registration and coverage by the school health programme

iii. Disease control: to identify / follow up of diagnosed patients suffering from specific diseases like TB, Leprosy etc

iv. Eligible Couple follow up and action plan through FP/Spacing/ counselling to avoid pregnancy below the age of 18 years.

v. Water quality monitoring including sanitation and chlorination

vi. Vector control measures monitoring

vii. IEC activities to SHGs, VHSCs & ASHAs. Weekly theme for IEC talks may be developed and followed.

viii. School health programme: To be started in June/ July in all the Govt. schools and social welfare hostels and all the children in the schools of

the area to undergo basic health screening initially and those identified as high risk to be ear marked for follow up visits.

1. each child to have a card
2. DPT/ TT as per the schedule are given
3. De-worming to be under taken in the initial visit and the next after a six months period.
4. Children requiring specialist care are to be referred to the concerned specialist at a referral unit.
5. Further follow up visits to the schools may be once in 3 months.

ix. Health Education; IEC Campaign

Action Plan – Road Map for Revitalisation

26. The DMHO of the district shall be responsible for preparation of action plan for the 'Revitalisation of Primary Health Care' for the district duly following these guidelines. The DMHO shall undertake this exercise under the overall supervision of the **District Collector and District Magistrate with the technical guidance of the Regional Director and the Nodal Officer of the Health Department and in partnership with the District Coordinator of Hospital Services.** The DMHO and DCHS together will hold workshops with all Medical Officers to explain the programme of action and the Medical Officers in turn will undertake mapping and service area rationalisation exercise for the ASHAs, Sub-centres and prepare proposals for the PHC. Based on this exercise, the DMHO and DCHS with the inputs from Dy. DMHO, Programme Officers, Medical Officers and other functionaries will prepare the action plan duly paying attention to the following paras. The Action Plan will be reviewed and approved by the District Health Committee chaired by the District Collector. In case of ITDA areas, the entire proposal must be reviewed and approved by the Project Officer of ITDA.

27. The Plan should include: **a) delineation of the service area of ASHA, Sub-Centre and PHC; b) constitution of CHN Clusters and identification of Referral Institution and establishment of CHCU; b) proposal for rational deployment of staff, equipment and other resources; d) measures for strengthening of the civil works and supply of essential equipment; e) delineation of route maps and schedule for fixed-day visit to sub-centres and villages; f) schedule for preparation of village / sub-centre and PHC Health Plans; and g) proposals for strengthening the health system, including establishment / upgradation of health facilities in 2011-12, 2012-13 and 2013-14.**

28. The Action Plan should also include the following *inter alia*:

a) Upgradation or shifting of Health Institutions with detailed reasons for the proposal.
b) Merger of other vertical programme institutions – both physically and functionally – with the PHC / CHC / Area / District Hospitals.
c) Proposal for transfer of institutions from DH to APVVP and vice versa.
d) Proposals for rationalising the deployment of Human Resources with detailed reasons thereof.
e) Proposal for rationalising the equipment deployment – identify equipment that is not being used that could be transferred to another health institution along with equipment required by each institution with reasons for such a proposal duly indicating the time frame within which it is required.
f) Civil works Required – duly phasing them into those requiring immediate approval, and those that can be / should be taken up during the next three years (duly indicating the year in which it could be taken up) along with reasons for the proposals. The proposal should explain the description of the civil works required, estimated cost and the rationale for the proposal.
g) Detailed Plan of Action for brining the PHC / CHC in conformity with the IPHS standards by 2015.

Additional Issues

29. It should be noted that the above guidelines are for the purpose of general guidance, and the entire exercise must be done with the participation of all medical officers, nurses and paramedical staff duly dictated by the goals, purpose and the objective for which it is being done, which is to secure quality health care for all, especially the most disadvantaged and the most excluded.

30. The entire exercise must be completed and comprehensive proposals shall be submitted to the Government through the Commissioner of Health and Family Welfare by 15 May 2010.

DR P VENKAT RAMESH
SECRETARY TO THE GOVERNMENT

To
The Commissioner of Health and Family Welfare
The Director of Public Health and Family Welfare

The Commissioner of AP Vaidya Vidhana Parishad
All District Collectors and District Magistrates
The Project Officers of ITDA
All District Medical and Health Officers
All District Coordinators of Health Services of APVVP
All Superintendents of Area and District Hospitals

Copy to:

1. The Secretary to Government of India, Ministry of Health and Family Welfare, Nirman Bhavan, New Delhi
2. The Mission Director, NRHM, Nirman Bhavan, New Delhi.
3. The Director, NIHFW, New Delhi.
4. The Principal Secretary to the Chief Minister (KR)
5. The Special Chief Secretary to Government of AP, Tribal Welfare Department.
6. Director of Medical Education / Director of IPM / Commissioner of AYUSH / Director General of Drug Control Administration / Managing Director of APHMHIDC / Project Director of APSACS / Director of Indian Institute of Health & Family Welfare / Vice-Chancellor of NTR University of Health Sciences /
7. The Commissioner of Tribal Welfare
8. The OSD to Hon'ble Minster (ME), AP Secretariat, Hyderabad.
9. The OSD to Hon'ble Minster (H&FW), AP Secretariat, Hyderabad.
10. The OSD to Hon'ble Minster (Aarogyasri) AP Secretariat, Hyderabad.
11. All Regional Directors of Health
12. All Superintendents of Teaching Hospitals
13. Principals of Medical College of the state
14. The PS to the Principal Secretary to Government, Medical and Health Department
15. All officials of SPIU of HM &FW Department
16. Representative, Family Health International Hyderabad
17. Director, Indian Institute of Public Health, Hyderabad
18. All Nodal Officers of the Medical and Health Department

//FORWARDED BY ORDER//

SECTION OFFICER

Annexure 1 to G.O.Ms 92 of MH&FW Department dated 23 April 2010

CONVERSION OF GOVERNMENT DISPENSARIES / MM UNITS / L F DISPENSARIES INTO PHCs

Sl.	Name of the District	Mandal	Name of the existing	Name of the new institution with	Remarks
1	2	3	4	5	6
1	**SRIKAKULAM**	Gara	GD Kalingapatnam	PHC Kalingapatnam	
2		Amdalavalasa	GD Akkulapeta	PHC Akkulapeta	
3		Ponduru	GD Tadivalasa	PHC Tadivalasa, Ponduru(M)	
4		V.Kothur	GD Venkatapuram	PHC Venkata-puram, V.Kota (M)	
5		Kavirty	GD Rajapuram	PHC Rajapuram, Kaviti (M)	
6		Kavirty	GD Manikyapuram	PHC Manikyapuram, Kaviti (M)	
7		Kavirty	GD Borivanka	PHC Borivanka, Kaviti (M)	
8		Narsannapeta	GD Urlam	PHC Urlam, Narsannapeta (M)	
9		Ichapuram	M.M.U. Ichapuram	PHC Ichapuram	
10		L.N.Peta	SHC, LN Peta	PHC, LN Peta	Merged with existing PHC
11		Hiramandalam	SHC,Hiramandalam	PHC,Hiramandalam	
12		Kavity	SHC,Belgaon	PHC,Belgaon	
13		Ponduru	Govt.Hl.Ponduru	CHC Ponduru	
14		Amadalavalasa	Govt.Hl.Amadalavalasa	CHC Amadalavalasa	
1	**VIZIANAGARAM**	Kothavalasa	GD Kothavalasa	PHC Baligattam, Kothavalasa (M)	
2		Gurla	GD Kotagandedu	PHC Kotagandedu, Gurla (M)	
3		Garividi	GD Konuru	PHC Konuru, Garividi (M)	
4		Balijapeta	GD Chilakalapalli	Merged with PHC Balijapeta	
5		G.L.Puram	GD Gorada	PHC Gorada	
6		Kurupam	M.M.Unit Neelakatapuram	PHC Neelakatapuram	
7		Jiyyammavalasa	M.M.Unit Jiyyammavalasa	Merged with proposed CHC	
8		Salur	M.M.Unit Mamidipalli	PHC Baguvalasa by changing H.Q.	
9		G.L.Puram	GTH Bhadragiri	CHC Bhadragiri, G.L.Puram (M0	
1	**VISAKHAPATNAM**	Ravikamatham	GD Kothakota	PHC Kothakota, Ravikamatham (M)	

2		V.Madugula	GD Kinthali	PHC Kinthali (M) V.Madugula	
3		Pedagantyada	GD Pedagantyada	PHC Pedagantyada	
4		Anakapalli	GD Thagarampudi	PHC Thagarampudi	
5		G.K.veedhi	M.M.Unit R.V.Nagar	PHC R.V.Nagar	
6		G.K.veedhi	M.M.Unit Pedavalasa	Merged with existing PHC	
7		Arukuvally	M.M.Unit Sukarmetta	PHC Sukarmetta	
8		Munchingput	M.M.Unit Kilagada	Merged with PHC Dumbrigade	
9		Dumbrigade	M.M.Unit Araku	PHC Seeleru	
10		Pedabailu	M.M.Unit Pedabailu	Merged with PHC Pedabailu	
1	**EAST GODAVARI**	Gollaprolu	GD Gollaprolu	PHC Gollaprolu	
2		Pithapuram	GD Mallam	PHC Mallam	
3		Prathipadu	GD Shanti Asramam	PHC Shanti Asramam	
4		Prathipadu	GD Peddipalem	PHC Peddipalem	
5		Kirlampudi	GD Geddanaopalli	PHC Geddanaopalli	
6		Kirlampudi	GD Veeravaram	PHC Veeravaram	
7		Korukonda	GD Dosakayapalli	PHC Dosakayapalli	
8		Jaggampeta	GD Katravulapalli	PHC Katravulapalli	
9		Peddapuram	GD Pulimeru	PHC Pulimeru	
10		U.Kothapalli	GD Nagulapalli	PHC Nagulapalli	
11		U.Kothapalli	GD Komaragiri	PHC Komaragiri	
12		Pedapudi	GD Peddada	PHC Peddada	
13		Pedapudi	GD Samapara	PHC Samapara	
14		Kakinada (U)	Unit - Hospital, APSP,	Condinued as Unit Hospital	
15		Rajanagaram	GD Palacherla	PHC Palacherla	
16		Mandapeta	GD Kesavaram	PHC Kesavaram	
17		Kapileswarapuram	GD Atchutapuram	PHC Atchutapuram	
18		Kapileswarapuram	GD Vakatippa	PHC Vakatippa	
19		Alamuru	GD Chopella	PHC Chopella	
20		K.Gangavaram	GD Dangeru	PHC Dangeru	
21		Ambajipet	GD Mukkamala	PHC Mukkamala	
22		Inavilli	GD Veeravallipalem	PHC Veera-vallipalem	

23		1.Polavaram	GD Kesanakurru	PHC Kesanakurru	
24		Inavilli	GD G.Vemavaram	PHC G.Vemavaram	
25		Allavaram	GD Bendamur Lanka	PHC Bendamur Lanka	
26		Mamidikuduru	GD Lutukurru	PHC Lutukurru	
27		Saknine tipalli	GD Rameswaram	PHC Rameswaram	
28		Biccavolu	GD Konkuduru	PHC Konkuduru	
29		Karapa	GD Velangi	PHC Velangi	
30		Katrenikona	M.M.Unit Pallamkurru	PHC Pallamkurru	
31		Ramchodavaram	M.M.Unit Rampachodavaram	PHC Seethapalli	
32		Kapileswarapuram	GH Kapileswarapuram	CHC Kapileswarapuram	
		Kapileswarapuram	SHC Kapileswarapuram	PHC Peddapalla	
33		Samalkota	GH Samalkota	CHC Samalkota	
34		K.Gangavaram	GH Pekeru	PHC Pekeru	
1	**WEST GODAVARI**	Tallapudi	GD Anadevarapeta	PHC Anadevarapeta, Tallapudi (M)	
2		Chagallu	GD Marikondapadu	PHC Marikondapadu, Chagallu.	
3		Ganapavaram	GD Pippara	PHC Pippara, Ganapavaram (M)	
4		Buttaigudem	UM.M.Unit K.R.Puram-I	PHC K.R.Puram-I, Buttaigudem (M)	
5		Buttaigudem	GD Doramamidi	PHC Doramamidi	
6		Nidadavole	GD Nidadavole	CHC Nidadavole	
7		Buttaigudem	M.M.Unit K.R.Puram - II	PHC Gaddapalli	
8		T.Narsapuram	M.M.Unit Borrampalem	PHC Borrampalem	
9		Bhimavaram	M.M.Unit Bhimavaram	PHC Konithiwada	
1	**KRISHNA**	Ghantasala	LFD Ghantasala	PHC Ghantasala	
2		Ghantasala	SHC Srikakulam	PHC Srikakulam	
3		Pamarru	GD Zamigolvepalli	PHC Zamigolvepalli	
4		Pamidimukalla	LFD .Kapileswarapuram	PHC Kapileswarapuram	
5		Unguturu	GD Indupalli	PHC Indupalli	
6		LFD Kanumuru	Pamarru	PHC Kanumuru	
7		MMU Kolletikota	Kaikalur	Merged with existing PHC	
8		GH pamarru	Pamarru	PHC pamarru	
9		GH Yalamarru	Peddaupparapadu	PHC Yalamarru	

10		GH manda-pakala	Koduru	PHC mandapakala	
11		Gh Kowtharam	Gudlavalleru	PHC Kowtharam	
2		Nakrekallu	SHC Nakrekallu	PHC Nakrekallu	Both Dispensary & SHC merged
3		Pidugurala	GD Karalapadu	PHC Karalapadu	
4		Repalle	M.M.Unit Repalle	PHC Gangedipalem, Repalle (M)	
5		Ipuru	SHC Inomalla	PHC Muppalla	
6		SHC Mulpuru	Mulpuru	PHC Venigalla, pedakakani (M)	
7		GD Edlapalli	Tsundur	PHC Kavuru, Chilakaluripeta (M)	
8		GD Intur	Amarthalur	PHC Ponnekallu, Thadikonda (M)	
9		GD Vatticherukur	Vattocherukur	PHC Vatticherukur	
1	**PRAKASAM**	Pamur	GD Pamur + SHC	PHC Pamur	
2		Ballikureva	GD Guntupalli	PHC Guntupalli	
3		Giddalur	GD Sanjeevaraopet	PHC Sanjeevaraopet	
4		N.G.Padu	G.D.Pothavaram	PHC Pothavaram	
5		N.G.Padu	GD Timmasamudram	PHC Timmasamudram	
6		Vetapalem	GD Pandillapalli	PHC Pandillapalli	
7		Martur	GD Dronadula	PHC Dronadula	
8		Incollu	GD Duddakur	PHC Duddakur	
9		Pamur	SHC Pamur	Merged with existing PHC Pamur	
10		Cumbum	SHC Cumbum	PHC Lingapuram	
11		Komorolu	GH Komorolu (12 Bedded)	PHC Komorolu	
12		Mundlamur	GH Marella	PHC Marella	
13		Chirala	M.M.Unit Chirala	PHC Uppugunduru,	
14		P.Dornala	M.M.Unit P.Dornala	New PHC Karavadi,	
1	**NELLORE**	Kavali	M.M.Unit Kavali	PHC Sarvayapalem	
2			M.M.Unit Nellore	PHC South mopur	
3			SHC Allur	CHC Allur , GH Allur merged with CHC Allur	
			GH Allur		
4		Vidavalur	GH Vidavalur	PHC Vidavalur	

5		Venkatagiri	GH Venkatagiri	PHC Bangarupeta	
7		Sangam	GD Sangam	PHC Sangam	
8		T.P.Gudur	GD, Kodur	PHC Kodur	
			SHC Kodur		
9		Indukurpeta	GD Jagadevpeta	PHC Jagadevpeta	
10		Kaluvoya	GD Kullur	PHC Kullur	
11		Chejerla	GD Chittalur	PHC Chittalur	
12		Chillakur	GD Vallipedu	PHC Vallipedu	
13			GD Varagalli	PHC Varagalli	
14			G.D.Nidigurthy	PHC Nidigurthy	
15			G.D.Chinnathota	PHC Chinnathota	
16			G.D.Gunapatipalem	PHC Gunapatipalem	
17			SHC Pedapariya	PHC Pedapariya	
			GD, Pedapariya		
1	**CHITTOOR**	Yadamaris	GD Madhireddy-palle	PHC Madhireddy-palle	
2		Pulicherla	GD Kallur	PHC Kallur	
3		R.C.Puram	GD Kuppambadur	PHC Kuppambadur	
4		S.R.Puram	GD Arimakulapalle	PHC Arimakulapalle	
5		Thamballapalle	GD Kosuvaripalle	PHC Kosuvaripalle	
1	**KADAPA**	Obulavaripalli	GD Mukkavaripalli	PHC Mukkavaripalli	
2		Vempalli	SHC Vempalli	PHC Tallapalli	
3		L.R.Palli	SHC L.R.Palli	PHC Konampeta	
4		Mydukur	GD Onipenta	PHC Onipenta	
5		Kadapa	M.M.Unit Kadapa	PHC Akkayapalli, Kadapa (R)	
6			Rural Kadapa		
1	**ANANTHAPUR**	Vajrakanuru	GD, Vajrakanuru	PHC Vajrakanuru	
2		Madakasine	GD, Neela-kantapuram	PHC Neelakantapuram	
3		Thanakallur	GD, Kokkanti	PHC Kokkanti	
4		Bommanahal	GD, Sreedharegatta	PHC Sreedharegatta	
5		Kanekal	GD, Garudachedu	PHC Garudachedu	
6		Uravakonda	GD, Raketla	PHC Raketla	

7		MMU Kalyandurg	Kalyandurg	PHC Avuladatla Rayadurgam (M)	
1	**KURNOOL**	Atmakur	SHC Bairluty	PHC Bairluty	
2		Sanjamale	SHC Sanjamale	PHC Sanjamale	
3					
4		Nandavaram	GD, Halaharvi	PHC, Halaharvi	
5		Sirivelle	GD, Yerraguntla	PHC, Yerraguntla	
6		Rudravaram	GD, Narsapuram	PHC, Narsapuram	
7		Kurnool	GD, Gargeyapuram	PHC Gargeyapuram	
8		Orvakal	GD, Narnoor	PHC Narnoor	
9		Midthur	GD, Kadumur	PHC Kadumur	
10		Pagidyala	GD, Prathakota	PHC Prathakota	
11		Uyyalawada	GD, Mayelur	PHC Mayelur	
12		Sanjamala	GD, Nossam	PHC Nossam	
13		Owk	GD, Uppalapadu	PHC Uppalapadu	
14		Halagunda	GD, Gajjanahalli	PHC , Gajjanahalli	
1	**MAHABUBNAGAR**	Amarabad	M.M.Unit Mannanur	Merged with existing PHC Mannahur	
2		Koilkonda	GD Koilkonda	CHC Koilkonda	
3		Kosigi	CHl.Kosigi	CHC Kosigi	
1	**RANGA REDDY**	Manchal	GOVT.CIVIL DISPENSARY	PHC ARUTLA	
2		Dharur	GCH Dharur	PHC Dharur	
3		Malkajgiri	GOVT.CIVIL Alwal	PHC Alwal	
1	**MEDAK**	Jagdevpur	Jagdevpur GCD	PHC Jagdevpur	
2		Hathnoora	Chintalcheru GCD	PHC Chintalcheru	
3		Jharasangam	Jharasangam GD	PHC Jharasangam	
			Jharasangam SHC		
4		Koheer	Koheer SHC	PHC Bilalpur	
1	**NIZAMABAD**	Balkonda	GH Balkonda (30 Bedded)	PHC Kisannagar	
2		Balkonda	Kisannagar		
3		Bichkonda	GH Bichkonda	CHC Bichkonda	
4		Kotgir	GH Kotgir	CHC Kotgir	
5		Chowtapalli	SHC Cowtapalli	SHC Chowtapally	

1	**ADILABAD**	Sarangapur	GD Sarangapur	PHC Sarangapur	
2		Lohesra	GD Lahesra	PHC Lahesra	
3		Jainad	SHC Jainad	PHC Jainad	
			GD Jainad		
4		Koutala	GD Babapur Gangapur	PHC Babapur Gangapur	
1	**KARIMNAGAR**	Eligedu	GD Eligaidu converted as	PHC Eligaidu	
2		Eligedu	SHC Eligaidu	PHC Bornapalli	
3		Huzurabad	GD KC Camp, Huzurabad	PHC KC Camp, Huzurabad	
4		Jagityal	GD Dharoor Camp,	PHC Dharoor Camp,	
5		Mahadevpur	M.M.Unit Mahadevpur	PHC Kaleswaram	
6		Veenavanka	GH Veenavanka,	PHC Veenavanka,	
7		Ramagundam	GH Ramagundam	PHC Ramagundam	
8		Thimmapur	GD LMD Colony	CHC LMD Colony	
9			GH Basanthnagar	CHC Basanthnagar	
1	**WARANGAL**	Hanamkonda	GH Kazipet	CHC Kazipet	
2		Cherial	SHC Cherial	PHC Mustiyala	
1	**KHAMMAM**	Dummugudem	GH Dummugudem	Both Merged with PHC Dummugudem	
			SHC Dummugudem		
2		Venkatapuram	GH Venkatapuram	PHC Venkatapuram	
3		Chintoor	GH Chintoor	PHC Chintoor	
4		Thirumalayapalem	GH Sublaid	PHC Sublaid	
5		Garla	GH Garla	CHC Garla	
1	**NALGONDA**	Athmakur	SHC Athmakur	PHC Athmakur (S)	
2		Nereducherla	SHC Penchikaladinne	PHC Penchikaladinne	
3		Nandigudem	GH Nandigudem	CHC Nandigudem	
4		Munagala	GH Munagala	PHC Munagala	